Table of Contents

# SECURITIES AND EXCHANGE COMMISSION

**WASHINGTON, DC 20549**

# FORM 10-Q

**(Mark One)**

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

**For the quarterly period ended June 30, 2005**

**OR**

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

**For the transition period from_____ to _____**

**Commission file number 000-33395**

# Centene Corporation

**(Exact name of registrant as specified in its charter)**

| **Delaware** | **42-1406317** |
|---|---|
| **(State or other jurisdiction of incorporation or organization)** | **(I.R.S. Employer Identification Number)** |
| **7711 Carondelet Avenue, Suite 800**<br>**St. Louis, Missouri** | **63105** |
| **(Address of principal executive offices)** | **(Zip Code)** |

**Registrant's telephone number, including area code:**
**(314) 725-4477**

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days: Yes ☒ No ☐

Indicate by check mark whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the Act). Yes ☒ No ☐

As of July 15, 2005, the registrant had 42,500,744 shares of common stock outstanding.

Table of Contents

**CENTENE CORPORATION**

**QUARTERLY REPORT ON FORM 10-Q**

**TABLE OF CONTENTS**

Table of Contents

## PART I

## FINANCIAL INFORMATION

**ITEM 1.** ***Financial Statements***

### CENTENE CORPORATION AND SUBSIDIARIES

### CONSOLIDATED BALANCE SHEETS
**(In thousands, except share data)**

| | June 30, 2005 | December 31, 2004 |
|---|---|---|
| | (Unaudited) | |
| **ASSETS** | | |
| Current assets: | | |
| Cash and cash equivalents | $ 65,598 | $ 84,105 |
| Premium and related receivables, net of allowances of $437 and $462, respectively | 69,839 | 31,475 |
| Short-term investments, at fair value (amortized cost $65,453 and $94,442, respectively) | 65,337 | 94,283 |
| Other current assets | 16,482 | 14,429 |
| Total current assets | 217,256 | 224,292 |
| Long-term investments, at fair value (amortized cost $135,626 and $117,177, respectively) | 134,621 | 116,787 |
| Restricted deposits, at fair value (amortized cost $22,507 and $22,295, respectively) | 22,323 | 22,187 |
| Property, software and equipment | 48,479 | 43,248 |
| Goodwill | 130,262 | 101,631 |
| Other intangible assets | 15,188 | 14,439 |
| Other assets | 6,317 | 5,350 |
| Total assets | $ 574,446 | $ 527,934 |
| **LIABILITIES AND STOCKHOLDERS' EQUITY** | | |
| Current liabilities: | | |
| Medical claims liabilities | $ 153,593 | $ 165,980 |
| Accounts payable and accrued expenses | 31,045 | 31,737 |
| Unearned revenue | 9,657 | 3,956 |
| Current portion of long-term debt and notes payable | 486 | 486 |
| Total current liabilities | 194,781 | 202,159 |
| Long-term debt | 52,731 | 46,973 |
| Other liabilities | 8,215 | 7,490 |
| Total liabilities | 255,727 | 256,622 |
| Stockholders' equity: | | |
| Common stock, $.001 par value; authorized 100,000,000 shares; issued and outstanding 42,481,098 and 41,316,122 shares, respectively | 42 | 41 |
| Additional paid-in capital | 183,539 | 165,391 |
| Accumulated other comprehensive income: | | |
| Unrealized loss on investments, net of tax | (809) | (407) |
| Retained earnings | 135,947 | 106,287 |
| Total stockholders' equity | 318,719 | 271,312 |
| Total liabilities and stockholders' equity | $ 574,446 | $ 527,934 |

See notes to consolidated financial statements.

Table of Contents

**CENTENE CORPORATION AND SUBSIDIARIES**

**CONSOLIDATED STATEMENTS OF EARNINGS**
**(In thousands, except share data)**

| | Three Months Ended June 30, | | Six Months Ended June 30, | |
|---|---|---|---|---|
| | 2005 | 2004 | 2005 | 2004 |
| | (Unaudited) | | (Unaudited) | |
| **Revenues:** | | | | |
| Premiums | $ 348,416 | $ 231,330 | $ 679,360 | $ 454,020 |
| Services | 1,212 | 2,278 | 2,644 | 5,113 |
| Total revenues | 349,628 | 233,608 | 682,004 | 459,133 |
| **Expenses:** | | | | |
| Medical costs | 282,215 | 187,298 | 549,971 | 367,746 |
| Cost of services | 728 | 2,022 | 1,571 | 4,038 |
| General and administrative expenses | 44,365 | 28,351 | 86,824 | 56,728 |
| Total operating expenses | 327,308 | 217,671 | 638,366 | 428,512 |
| Earnings from operations | 22,320 | 15,937 | 43,638 | 30,621 |
| **Other income (expense):** | | | | |
| Investment and other income | 2,523 | 1,336 | 4,643 | 2,846 |
| Interest expense | (634) | (101) | (1,196) | (191) |
| Earnings before income taxes | 24,209 | 17,172 | 47,085 | 33,276 |
| **Income tax expense** | 8,960 | 6,359 | 17,425 | 12,325 |
| **Net earnings** | $ 15,249 | $ 10,813 | $ 29,660 | $ 20,951 |
| **Earnings per share:** | | | | |
| Basic earnings per common share | $ 0.36 | $ 0.27 | $ 0.71 | $ 0.52 |
| Diluted earnings per common share | $ 0.34 | $ 0.25 | $ 0.66 | $ 0.48 |
| **Weighted average number of shares outstanding:** | | | | |
| Basic | 42,203,946 | 40,721,466 | 41,884,044 | 40,552,742 |
| Diluted | 45,087,772 | 43,374,376 | 44,984,818 | 43,221,426 |

See notes to consolidated financial statements.

**CENTENE CORPORATION AND SUBSIDIARIES**

**CONSOLIDATED STATEMENTS OF CASH FLOWS**
**(In thousands)**

| | Six Months Ended June 30, | |
|---|---|---|
| | 2005 | 2004 |
| | (Unaudited) | |
| **Cash flows from operating activities:** | | |
| Net earnings | $ 29,660 | $ 20,951 |
| Adjustments to reconcile net earnings to net cash provided by operating activities — | | |
| Depreciation and amortization | 5,901 | 4,701 |
| Deferred income taxes | 1,191 | (914) |
| Tax benefits related to stock options | 3,782 | 1,507 |
| Stock compensation expense | 2,304 | 32 |
| Loss (gain) on sale of investments | 39 | (103) |
| Changes in assets and liabilities — | | |
| Premium and related receivables | (38,364) | (989) |
| Other current assets | (2,224) | (1,051) |
| Other assets | (946) | (330) |
| Medical claims liabilities | (12,387) | 3,536 |
| Unearned revenue | 5,701 | (23) |
| Accounts payable and accrued expenses | (2,716) | 3,747 |
| Other operating activities | 1,034 | (950) |
| Net cash (used in) provided by operating activities | (7,025) | 30,114 |
| **Cash flows from investing activities:** | | |
| Purchase of property, software and equipment | (8,768) | (5,082) |
| Purchase of investments | (74,928) | (154,342) |
| Sales and maturities of investments | 84,984 | 151,077 |
| Acquisitions, net of cash acquired | (21,342) | (7,005) |
| Net cash used in investing activities | (20,054) | (15,352) |
| **Cash flows from financing activities:** | | |
| Reduction of long-term debt and notes payable | (4,242) | (435) |
| Proceeds from borrowings | 10,000 | — |
| Proceeds from stock options and employee stock purchase plan | 2,864 | 1,805 |
| Other financing | (50) | — |
| Net cash provided by financing activities | 8,572 | 1,370 |
| Net (decrease) increase in cash and cash equivalents | (18,507) | 16,132 |
| **Cash and cash equivalents,** beginning of period | 84,105 | 64,346 |
| **Cash and cash equivalents,** end of period | $ 65,598 | $ 80,478 |
| Interest paid | $ 1,209 | $ 181 |
| Income taxes paid | $ 12,904 | $ 11,034 |
| **Supplemental schedule of non-cash investing and financing activities:** | | |
| Common stock issued for acquisitions | $ 8,995 | $ — |

See notes to consolidated financial statements.

**CENTENE CORPORATION AND SUBSIDIARIES**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**
**(Dollars in thousands, except share data)**

**1. Organization**

Centene Corporation (Centene or the Company) provides multi-line managed care programs and related services to individuals receiving benefits under government subsidized programs including Medicaid, Supplemental Security Income (SSI) and the State Children's Health Insurance Program (SCHIP). Centene's Medicaid Managed Care segment operates health plans under its own state licenses in seven states and contracts with other managed care organizations to provide risk and non-risk management services. Centene's Specialty Services segment contracts with Centene owned companies, as well as other healthcare organizations and state programs, to provide specialty services including behavioral health, nurse triage and treatment compliance.

**2. Basis of Presentation**

The unaudited interim financial statements herein have been prepared by the Company pursuant to the rules and regulations of the Securities and Exchange Commission (SEC). The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements for the latest fiscal year ended December 31, 2004. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2004 audited financial statements, have been omitted from these interim financial statements where appropriate. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

Certain 2004 amounts in the consolidated financial statements have been reclassified to conform to the 2005 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

The Company accounts for stock-based compensation under APB Opinion No. 25, "Accounting for Stock Issued to Employees." The Company has adopted the disclosure-only provisions of SFAS No. 123, "Accounting for Stock-Based Compensation," and SFAS No. 148, "Accounting for Stock-Based Compensation-Transition and Disclosure." The following table illustrates the effect on net earnings and earnings per share if a fair value based method had been applied to all awards.

| | Three Months Ended June 30, | | Six Months Ended June 30, | |
|---|---|---|---|---|
| | 2005 | 2004 | 2005 | 2004 |
| Net earnings | $15,249 | $10,813 | $29,660 | $20,951 |
| Stock-based employee compensation expense included in net earnings, net of tax | 752 | 8 | 1,429 | 20 |
| Stock-based employee compensation expense determined under fair value based method, net of tax | (2,052) | (789) | (4,032) | (1,496) |
| Pro forma net earnings | $13,949 | $10,032 | $27,057 | $19,475 |
| Basic earnings per common share: | | | | |
| As reported | $ 0.36 | $ 0.27 | $ 0.71 | $ 0.52 |
| Pro forma | 0.33 | 0.25 | 0.65 | 0.48 |
| Diluted earnings per common share: | | | | |
| As reported | $ 0.34 | $ 0.25 | $ 0.66 | $ 0.48 |
| Pro forma | 0.31 | 0.23 | 0.61 | 0.45 |

**3. Recent Accounting Pronouncements**

In December 2004 SFAS 123 (revised 2004), "Share Based Payment," (SFAS 123R) was issued. In March 2005 the SEC issued Staff Accounting Bulletin No. 107 (SAB 107). SAB 107 expresses views of the SEC staff regarding the interaction between SFAS 123R and certain SEC rules. SFAS 123R focuses primarily on accounting for transactions in which an entity obtains employee services in share-based payment transactions. SFAS 123R requires public entities to measure the cost of employee services received in exchange for an award of equity instruments based on the grant-date fair value of the award. The grant-date fair value of employee share options and similar instruments will be estimated using option-pricing models adjusted for the unique characteristics of those instruments. That cost will be recognized over the period during which an employee is required to provide service in exchange for the award. In April 2005 the SEC delayed the implementation of SFAS 123R for public companies until the first annual period beginning after June 15, 2005. SFAS 123R is required to be adopted by the Company by January 1, 2006.

The Company currently utilizes a closed form option-pricing model to measure the fair value of stock-based compensation for employees. SFAS 123R permits the use of this model or other models such as a lattice model. The Company has not yet determined which model it will use to measure the fair value of share-based grants to employees upon the adoption of SFAS 123R. The effect of expensing stock options in accordance with the original SFAS 123 is presented above under Note 2, Basis of Presentation. SFAS 123R also requires that the benefits associated with the tax deductions in excess of recognized compensation cost be reported as a financing cash flow, rather than as an operating cash flow as required under current literature. This presentation may reduce net operating cash flows and increase net financing cash flows in periods after the effective date. The amount of this excess tax deduction benefit was $3,782 and $1,507 in the six months ended June 30, 2005 and 2004, respectively.

In May 2005, SFAS No. 154, "Accounting Changes and Error Corrections – replacement of APB Opinion No. 20 and FASB Statement No. 3," (SFAS No. 154) was issued. SFAS No. 154 changes the accounting for and reporting of a change in accounting principle by requiring retrospective application to prior periods' financial statements of changes in accounting principle unless impracticable. SFAS No. 154 is effective for accounting changes made in fiscal years beginning after December 15, 2005. The Company does not expect the adoption of SFAS No. 154 to have a material impact on its results of operations, financial position or cash flows.

**4. Acquisitions**

***AirLogix***

In July 2005 the Company acquired AirLogix, Inc. (AirLogix) a respiratory disease management provider. The Company paid approximately $35,000 in cash plus transaction costs. If certain performance criteria are achieved, additional consideration of up to $5 million may be paid. The total purchase price will be allocated to the net tangible assets acquired according to estimated fair values. Any excess purchase price will be allocated to identifiable intangible assets and goodwill.

***SummaCare***

Effective May 1, 2005, the Company acquired certain Medicaid-related assets from SummaCare, Inc. for a purchase price of approximately $30,300. The purchase price and related transaction costs consisted of approximately $21,300 in cash and 318,735 shares of common stock. The cost to acquire the Medicaid-related assets has been preliminarily allocated to the assets acquired and liabilities assumed according to estimated fair values. The results of operations for SummaCare are included in the consolidated financial statements since May 1, 2005.

The preliminary purchase price allocation resulted in identified intangible assets of $1,900, representing purchased contract rights and a non-compete agreement, and goodwill of $28,400. The contract rights and non-compete agreement are being amortized over periods ranging from five to ten years. The acquired goodwill is deductible for tax purposes. Pro forma disclosures related to the acquisition have been excluded as immaterial.

***FirstGuard***

The Company purchased FirstGuard Inc. and FirstGuard Health Plan, Inc. (collectively, FirstGuard) from Swope Community Enterprises (Swope) effective December 1, 2004. Prior to the acquisition of FirstGuard, FirstGuard, Inc. acquired the 20% interest in FirstGuard Health Plan Kansas, Inc. held by a third-party. Swope has indemnified Centene with respect to any claims arising out of the purchase of the 20% interest. Centene paid approximately $96,020 in cash and transaction costs. In accordance with terms in the agreement, the purchase price may be adjusted on certain conditions up to sixteen months after the acquisition date. The results of operations for FirstGuard are included in the consolidated financial statements since December 1, 2004.

The purchase price and costs associated with the acquisition exceeded the preliminary estimated fair value of the net tangible assets acquired by approximately $91,959. The Company has preliminarily allocated the excess purchase price over the fair value of the net tangible assets acquired to identifiable intangible assets of $8,000 and associated deferred tax liabilities of $3,040 and goodwill of $86,999. The identifiable intangible assets have an estimated useful life of ten years. The acquired goodwill is not deductible for income tax purposes.

**5. Earnings Per Share**

The following table sets forth the calculation of basic and diluted net earnings per common share:

| | Three Months Ended June 30, | | Six Months Ended June 30, | |
|---|---|---|---|---|
| | 2005 | 2004 | 2005 | 2004 |
| Net earnings | $ 15,249 | $ 10,813 | $ 29,660 | $ 20,951 |
| Shares used in computing per share amounts: | | | | |
| Weighted average number of common shares outstanding | 42,203,946 | 40,721,466 | 41,884,044 | 40,552,742 |
| Common stock equivalents (as determined by applying the treasury stock method) | 2,883,826 | 2,652,910 | 3,100,774 | 2,668,684 |
| Weighted average number of common shares and potential dilutive common shares outstanding | 45,087,772 | 43,374,376 | 44,984,818 | 43,221,426 |
| Basic earnings per common share | $ 0.36 | $ 0.27 | $ 0.71 | $ 0.52 |
| Diluted earnings per common share | $ 0.34 | $ 0.25 | $ 0.66 | $ 0.48 |

The calculation of diluted earnings per common share for the three months ended June 30, 2005 and the six months ended June 30, 2005 excludes the impact of 160,655 shares related to stock options, unvested restricted stock and restricted stock units which are anti-dilutive. There were no anti-dilutive shares for the periods presented in 2004.

**6. Contingencies**

Aurora Health Care, Inc. (Aurora) provides medical professional services under a contract with the Company's Wisconsin health plan subsidiary. In May 2003, Aurora filed a lawsuit in the Milwaukee County Circuit Court claiming the Company had failed to adequately reimburse Aurora for services rendered during the period from 1998 to the present. In 2004 the Court dismissed the claims as filed, but allowed Aurora to replead and seek a declaratory ruling clarifying the contract with respect to reimbursement for ambulatory surgery services. In March 2005 the Court granted Aurora summary judgment related to that claim. The Company is appealing the Court's ruling. Although the exact amount of the dispute has not been determined, Aurora claims it exceeds $8,000. The Company continues to dispute the claim and plans to continue vigorously defending this matter.

The Company is routinely subject to legal proceedings in the normal course of business. While the ultimate resolution of such matters are uncertain, the Company does not expect the result of these matters to have a material effect on its financial position or results of operations.

**7. Segment Information**

Factors used in determining the reportable business segments include the nature of operating activities, existence of separate senior management teams, and the type of information presented to the Company's chief operating decision makers to evaluate all results of operations.

Centene operates in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies including behavioral health, nurse triage and treatment compliance functions.

Segment information for the three months ended June 30, 2005, follows:

| | Medicaid Managed Care | Specialty Services | Eliminations | Consolidated Total |
|---|---|---|---|---|
| Revenue from external customers | $ 347,970 | $ 1,658 | $ — | $ 349,628 |
| Revenue from internal customers | 17,770 | 8,549 | (26,319) | — |
| Total revenue | $ 365,740 | $10,207 | $ (26,319) | $ 349,628 |
| Earnings before income taxes | $ 25,192 | $ (983) | $ — | $ 24,209 |

Segment information for the three months ended June 30, 2004, follows:

| | Medicaid Managed Care | Specialty Services | Eliminations | Consolidated Total |
|---|---|---|---|---|
| Revenue from external customers | $ 231,731 | $ 1,877 | $ — | $ 233,608 |
| Revenue from internal customers | 15,027 | 5,072 | (20,099) | — |
| Total revenue | $ 246,758 | $ 6,949 | $ (20,099) | $ 233,608 |
| Earnings before income taxes | $ 17,124 | $ 48 | $ — | $ 17,172 |

Segment information for the six months ended June 30, 2005, follows:

| | Medicaid Managed Care | Specialty Services | Eliminations | Consolidated Total |
|---|---|---|---|---|
| Revenue from external customers | $ 678,513 | $ 3,491 | $ — | $ 682,004 |
| Revenue from internal customers | 34,818 | 16,633 | (51,451) | — |
| Total revenue | $ 713,331 | $20,124 | $ (51,451) | $ 682,004 |
| Earnings before income taxes | $ 48,070 | $ (985) | $ — | $ 47,085 |

Segment information for the six months ended June 30, 2004, follows:

| | Medicaid Managed Care | Specialty Services | Eliminations | Consolidated Total |
|---|---|---|---|---|
| Revenue from external customers | $ 454,846 | $ 4,287 | $ — | $ 459,133 |
| Revenue from internal customers | 29,557 | 9,777 | (39,334) | — |
| Total revenue | $ 484,403 | $14,064 | $ (39,334) | $ 459,133 |
| Earnings before income taxes | $ 33,462 | $ (186) | $ — | $ 33,276 |

**8. Comprehensive Earnings**

Differences between net earnings and total comprehensive earnings resulted from changes in unrealized gains and losses on investments available for sale follows:

| | Three Months Ended June 30, | | Six Months Ended June 30, | |
|---|---|---|---|---|
| | 2005 | 2004 | 2005 | 2004 |
| Net earnings | $15,249 | $ 10,813 | $29,660 | $20,951 |
| Reclassification adjustment, net of tax | 42 | (380) | 54 | (355) |
| Change in unrealized gain (loss) on investments, net of tax | 747 | (2,347) | (456) | (1,854) |
| Total comprehensive earnings | $16,038 | $ 8,086 | $29,258 | $18,742 |

**ITEM 2.** ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing, and in our annual report on Form 10-K for the year ended December 31, 2004. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth below under "Factors that May Affect Future Results and the Trading Price of Our Common Stock."

## OVERVIEW

We are a multi-line managed care organization that provides Medicaid and Medicaid-related programs and related services to organizations and individuals through government subsidized programs, including Medicaid, Supplemental Security Income (SSI) and the State Children's Health Insurance Program (SCHIP). We operate health plans in seven states. We also provide specialty services through contracts with our health plans, as well as other healthcare organizations and state programs. These specialty services include behavioral health, nurse triage and treatment compliance.

## RECENT ACQUISITIONS AND NEW BUSINESS IMPLEMENTATION

In July 2005 we acquired AirLogix Inc. (AirLogix) for a purchase price of approximately $35.0 million plus transaction costs. AirLogix is a respiratory disease management provider. We will allocate the total purchase price to the net tangible assets acquired according to estimated fair values. Any excess purchase price will be allocated to identifiable intangible assets and goodwill.

In July 2005 we were awarded Medicaid contracts in Georgia by the Georgia Department of Community Health, subject to regulatory approval. Membership operations will commence January 1, 2006. Our subsidiary, Peach State Health Plan, Inc., will manage care for a portion of the Medicaid and SCHIP recipients in the Atlanta and Central regions.

Effective July 1, 2005, we began performing under our contract with the State of Arizona to facilitate the delivery of mental health and substance abuse services to behavioral health recipients in Arizona.

Effective May 1, 2005, we acquired certain Medicaid-related assets of SummaCare, Inc. for a purchase price of approximately $30.3 million. This transaction allows us to serve approximately 37,500 members in Ohio. The results of operations of this entity are included in our consolidated financial statements beginning May 1, 2005. The purchase price allocation resulted in estimated identified intangible assets of $1.9 million, representing purchased contract rights and a non-compete agreement, and goodwill of $28.4 million. The contract rights and non-compete agreement are being amortized over periods ranging from five to ten years.

Effective December 1, 2004, we acquired FirstGuard, Inc. and FirstGuard Health Plan, Inc., (FirstGuard) for a purchase price of $96.0 million. FirstGuard serves approximately 143,000 members in Kansas and Missouri. The results of operations of this entity are included in our consolidated financial statements beginning December 1, 2004. The preliminary purchase price allocation resulted in estimated identifiable intangible assets of $8.0 million and goodwill of $87.0 million. The estimated identifiable intangible assets are being amortized over an estimated life of ten years.

Effective January 1, 2004, we commenced operations in Ohio through the acquisition of the Medicaid-related assets of Family Health Plan, Inc. (FHP) for a purchase price of $6.9 million. We are now serving 22,100 members in Toledo, Ohio. The results of operations of this entity are included in our consolidated financial statements beginning January 1, 2004. The purchase price allocation resulted in identified intangible assets of $1.8 million, representing purchased contract rights, provider network and a non-compete agreement, and goodwill of $5.1 million. The contract rights, provider network and non-compete agreement are being amortized over periods ranging from five to ten years.

## REVENUE AND EXPENSE DISCUSSION AND KEY METRICS

### Revenues and Revenue Recognition

We generate revenues in our Medicaid Managed Care segment primarily from premiums we receive from the states in which we operate to provide health benefits to our members. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments during the month we provide services and recognize premium revenue during the period in which we are obligated to provide services to our members. Revenues are recorded based on membership and eligibility data provided by the states, which may be adjusted by the states for updates to this data. In addition, revenue is adjusted for rebates due to the states in the event profits exceed established levels. These adjustments are immaterial in relation to total revenue recorded and are reflected in the period known.

Our Specialty Services companies generate revenues from a variety of sources. Our behavioral health company generates revenue via capitation payments from our health plans, state contracts and others. It also receives fees for certain school programs in Arizona. Our treatment compliance program receives fee income from the manufacturers of pharmaceuticals. Our nurse triage line receives fees from health plans, physicians and other organizations for providing continuous access to nurse advisors.

Premiums collected in advance are recorded as unearned revenue. Premiums due to us are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and our management's judgment on the collectibility of these accounts. As we generally receive premiums during the month in which services are provided, the allowance is typically not significant in comparison to total premium revenue and does not have a material impact on the presentation of our financial condition or results of operations.

The primary drivers of our increasing revenue have been membership growth in our Medicaid Managed Care segment. We have increased our membership through internal growth as well as acquisitions. From June 30, 2004 to June 30, 2005, we increased our membership by 54.8% of which 21.1% was organic and 33.7% from acquisitions. The following table sets forth our membership by state:

| | June 30, | |
|---|---|---|
| | 2005 | 2004 |
| Indiana | 152,800 | 132,900 |
| Kansas | 103,000 | — |
| Missouri | 39,900 | — |
| New Jersey | 52,900 | 54,000 |
| Ohio | 59,600 | 23,800 |
| Texas | 243,800 | 155,300 |
| Wisconsin | 173,400 | 167,300 |
| Total | 825,400 | 533,300 |

The following table sets forth our membership by line of business:

| | June 30, | |
|---|---|---|
| | 2005 | 2004 |
| Medicaid | 637,300 | 460,300 |
| SCHIP | 176,200 | 63,200 |
| SSI | 11,900 | 9,800 |
| Total | 825,400 | 533,300 |

During the last 12 months, we entered the Kansas and Missouri markets through our acquisition of FirstGuard. We increased our Texas membership by approximately 83,000 from the SCHIP Exclusive Provider Organization (EPO) contract effective September 1, 2004. We increased our membership in Ohio through our acquisition of the Medicaid-related assets of SummaCare, Inc. Our membership increased in Indiana and Wisconsin from additions to our provider networks, increases in counties served and growth in the overall number of Medicaid beneficiaries.

**Operating Expenses**

Our operating expenses include medical costs, cost of services, and general and administrative expenses.

Our medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty product claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process unpaid claims. Monthly, we estimate our IBNR based on a number of factors, including inpatient hospital utilization data and prior claims experience. As part of this review, we also consider the costs to process medical claims and estimates of amounts to cover uncertainties related to fluctuations in provider billing patterns, membership, products and inpatient hospital trends. These estimates are adjusted as more information becomes available. We utilize the services of independent actuaries who are contracted to review our estimates quarterly. While we believe that our process for estimating IBNR is actuarially sound, we cannot assure you that healthcare claim costs will not materially differ from our estimates.

Our results of operations depend on our ability to manage expenses related to health benefits and to accurately predict costs incurred. Our health benefits ratio represents medical costs as a percentage of premium revenues and reflects the direct relationship between the premium received and the medical services provided. The table below depicts our health benefits ratios by member category and in total:

| | Three Months Ended June 30, | | Six Months Ended June 30, | |
|---|---|---|---|---|
| | 2005 | 2004 | 2005 | 2004 |
| Medicaid and SCHIP | 80.9% | 80.5% | 80.8% | 80.5% |
| SSI | 85.2 | 97.8 | 89.3 | 98.5 |
| Total | 81.0 | 81.0 | 81.0 | 81.0 |

Our total health benefits ratio was flat in 2005 from 2004. The SSI health benefits ratio is affected by a low membership base and is subject to greater volatility as a percentage of premiums (although relatively immaterial in total dollars compared to total medical costs).

Our cost of services expenses include all direct costs to support the local functions responsible for generation of our services revenues. These expenses primarily consist of the salaries and wages of the physicians, clinicians, therapists and teachers who provide the services and expenses related to the clinics and supporting facilities and equipment used to provide services.

Our general and administrative expenses primarily reflect wages and benefits and other administrative costs related to health plans, specialty companies and the centralized functions that support all of our business units. The major centralized functions are claims processing, information systems and finance. Premium taxes are classified as general and administrative expenses. Our general and administrative expense ratio represents general and administrative expenses as a percentage of total revenues and reflects the relationship between revenues earned and the costs necessary to drive those revenues. The following table sets forth the general and administrative expense ratios by business segment and in total:

| | Three Months Ended June 30, | | Six Months Ended June 30, | |
|---|---|---|---|---|
| | 2005 | 2004 | 2005 | 2004 |
| Medicaid Managed Care | 10.5% | 10.2% | 10.6% | 10.3% |
| Specialty Services | 58.8 | 46.4 | 54.6 | 49.7 |
| Total | 12.7 | 12.1 | 12.7 | 12.4 |

The increase in the Medicaid Managed Care general and administrative expenses ratio reflects the costs to manage our growing membership, as well as premium taxes effective July 1, 2004 in New Jersey and September 1, 2004 for our EPO membership in Texas.

The Specialty Services ratio may vary depending on the various contracts and nature of the service provided and will have a higher general and administrative expense ratio than the Medicaid Managed Care segment. The results for the six months ended June 30, 2005 included approximately $1.5 million in start-up costs related to our behavioral health contract in Arizona.

**Other Income (Expense)**

Other income (expense) consists of investment and other income and interest expense.

- Investment income is derived from our cash, cash equivalents and investments. Information about our investments is included below under “Liquidity and Capital Resources.”
- Interest expense reflects interest on the borrowings under our credit facility, fees in conjunction with our credit facility and mortgage interest.

## RESULTS OF OPERATIONS

**Six Months Ended June 30, 2005 Compared to Six Months Ended June 30, 2004**

Summarized comparative financial data are as follows ($ in millions except per share data):

| | Six Months Ended June 30, | | |
|---|---|---|---|
| | 2005 | 2004 | % Change 2004-2005 |
| Premium revenue | $679.4 | $454.0 | 49.6% |
| Services revenue | 2.6 | 5.1 | (48.3)% |
| Total revenues | 682.0 | 459.1 | 48.5% |
| Medical costs | 550.0 | 367.8 | 49.6% |
| Cost of services | 1.6 | 4.0 | (61.1)% |
| General and administrative expenses | 86.8 | 56.7 | 53.1% |
| Earnings from operations | 43.6 | 30.6 | 42.5% |
| Investment and other income, net | 3.5 | 2.7 | 29.8% |
| Earnings before income taxes | 47.1 | 33.3 | 41.5% |
| Income tax expense | 17.4 | 12.3 | 41.4% |
| Net earnings | $ 29.7 | $ 21.0 | 41.6% |
| Diluted earnings per common share | $ 0.66 | $ 0.48 | 37.5% |

***Revenues***

Premium revenue for the six months ended June 30, 2005 increased 49.6% from the comparable period in 2004. This increase was due to the acquisition of the Medicaid-related assets of SummaCare, Inc., effective May 1, 2005; the acquisition of FirstGuard, effective December 1, 2004; organic growth in our existing markets; the addition of EPO members in Texas, effective September 1, 2004; and premium rate increases during the last 12 months.

Services revenue for the six months ended June 30, 2005 decreased 48.3% from the comparable period in 2004. This decrease was due to closing of clinic facilities in Texas and California as our behavioral health company transitioned from an employer of providers to a managed behavioral healthcare organization.

***Operating Expenses***

Medical costs increased 49.6% due to the growth in our membership as discussed above. Our health benefits ratio in 2005 was 81.0%, consistent with the comparable period in 2004.

Cost of services decreased 61.1% due to the decline in services revenue as discussed above.

General and administrative expenses increased 53.1% primarily due to expenses for additional facilities and staff to support our growth as well as the effect of premium taxes in New Jersey and Texas. For example, we incurred $1.5 million during the period in implementation costs related to our behavioral health contract in Arizona.

***Other Income***

Investment and other income increased 29.8% for the six months ended June 30, 2005 from the comparable period in 2004. The increase was due to higher average investment balances and an increase in market interest rates partially offset by higher interest expense from increased borrowings under our credit facility and mortgages.

***Income Tax Expense***

Our effective tax rate in 2005 was 37.0%, consistent with the comparable period in 2004.

**Three Months Ended June 30, 2005 Compared to Three Months Ended June 30, 2004**

Summarized comparative financial data are as follows ($ in millions except per share data):

| | Three Months Ended June 30, | | |
|---|---|---|---|
| | 2005 | 2004 | % Change 2004-2005 |
| Premium revenue | $348.4 | $231.3 | 50.6% |
| Services revenue | 1.2 | 2.3 | (46.8)% |
| Total revenues | 349.6 | 233.6 | 49.7% |
| Medical costs | 282.2 | 187.3 | 50.7% |
| Cost of services | 0.7 | 2.0 | (64.0)% |
| General and administrative expenses | 44.4 | 28.4 | 56.5% |
| Earnings from operations | 22.3 | 15.9 | 40.1% |
| Investment and other income, net | 1.9 | 1.3 | 53.0% |
| Earnings before income taxes | 24.2 | 17.2 | 41.0% |
| Income tax expense | 9.0 | 6.4 | 40.9% |
| Net earnings | $ 15.2 | $ 10.8 | 41.0% |
| Diluted earnings per common share | $ 0.34 | $ 0.25 | 36.0% |

***Revenues***

Premium revenue for the three months ended June 30, 2005 increased 50.6% from the comparable period in 2004. This increase was due to the acquisition of the Medicaid-related assets of SummaCare, Inc., effective May 1, 2005; the acquisition of FirstGuard, effective December 1, 2004; organic growth in our existing markets; the addition of EPO members in Texas, effective September 1, 2004; and premium rate increases during the last 12 months.

Services revenue for the three months ended June 30, 2005 decreased 46.8% from the comparable period in 2004. This decrease was due to closing of clinic facilities in Texas and California as our behavioral health company transitioned from an employer of providers to a managed behavioral healthcare organization.

***Operating Expenses***

Medical costs increased 50.7% due to the growth in our membership as discussed above. Our health benefits ratio in 2005 was 81.0% consistent with the comparable period in 2004.

Cost of services decreased 64.0% due to the decline in services revenue as discussed above.

General and administrative expenses increased 56.5% primarily due to expenses for additional facilities and staff to support our growth as well as the effect of premium taxes in New Jersey and Texas. For example, we incurred $1.3 million during the period in implementation costs related to our behavioral health contract in Arizona.

***Other Income***

Investment and other income increased 53.0% for the three months ended June 30, 2005 from the comparable period in 2004. The increase was due to higher average investment balances and an increase in market interest rates partially offset by higher interest expense from increased borrowings under our credit facility and mortgages.

***Income Tax Expense***

Our effective tax rate in 2005 was 37.0%, consistent with the comparable period in 2004.

## LIQUIDITY AND CAPITAL RESOURCES

Our operating activities used cash of $7.0 million in the six months ended June 30, 2005 and provided cash of $30.1 million in the comparable period in 2004. The decrease was primarily due to significant increases in premium and related receivables combined with a decrease in medical claims liabilities offset by an increase in net income. The increase in receivables resulted from an uncharacteristicly late capitation payment from the State of Wisconsin. This payment was held over the State's fiscal year-end and was received in July along with the July payment. The decrease in medical claims liabilities resulted from a decrease in our days in claims payable due primarily to the timing of annual physician incentive payments.

Our investing activities used cash of $20.1 million in the six months ended June 30, 2005 compared to $15.4 million in the comparable period in 2004. The largest component of investing activities related to the acquisition of certain Medicaid-related assets from SummaCare, Inc. Of the total purchase price of approximately $30.3 million, $21.3 million was paid in cash and the remaining $9.0 million was paid through the issuance of our common stock. Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our investment guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of June 30, 2005, our investment portfolio consisted primarily of fixed-income securities with an average duration of 1.8 years. Cash is invested in investment vehicles such as municipal bonds, corporate bonds, insurance contracts, commercial paper and instruments of the U.S. Treasury. The states in which we operate prescribe the types of instruments in which our regulated subsidiaries may invest their cash.

Our financing activities provided cash of $8.6 million in the six months ended June 30, 2005 compared to $1.4 million in the comparable period in 2004. The increase in cash was primarily related to proceeds of $10.0 million from borrowings on our revolving credit facility.

We spent $8.8 million and $5.1 million in the six months ended June 30, 2005 and 2004, respectively, on capital assets. We anticipate spending an additional $21 million on capital expenditures in 2005 related to office and market expansions and system upgrades.

At June 30, 2005, we had working capital, defined as current assets less current liabilities, of $22.5 million as compared to $22.1 million at December 31, 2004. Our investment policies are designed to provide liquidity and preserve capital. We manage our short-term and long-term investments to ensure that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term capital requirements as needed.

Cash, cash equivalents and short-term investments were $130.9 million at June 30, 2005 and $178.4 million at December 31, 2004. Long-term investments were $156.9 million at June 30, 2005 and $139.0 million at December 31, 2004, including restricted deposits of $22.3 million and $22.2 million, respectively. At June 30, 2005, cash and investments held by our unregulated entities totaled $27.4 million while cash and investments held by our regulated entities totaled $260.5 million.

We have a five-year $100 million Revolving Credit Agreement with various financial institutions and LaSalle Bank National Association as administrative agent and arranger. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. Under our current capital structure, borrowings under the agreement bear interest at LIBOR plus 1.25%. This rate may change under differing capital structures over the life of the agreement. The agreement is secured by the common stock and membership interests of our subsidiaries. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, minimum debt-to-EBITDA ratios and minimum tangible net worth. The agreement will expire in September 2009 or on an earlier date in the instance of a default as defined in the agreement. As of July 25, 2005, we had $75.0 million in borrowings outstanding under the agreement, $15.0 million in letters of credit outstanding and were in compliance with all covenants. We have initiated an amendment to our credit facility to increase the total amount available.

We have filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to $300 million of securities including common stock and debt securities. No securities have been issued under the shelf registration. We may publicly offer securities from time-to-time at prices and terms to be determined at the time of the offering.

There were no other material changes outside the ordinary course of our business in lease obligations or other contractual obligations in the six months ended June 30, 2005. Based on our operating plan, we expect that our available funding will be sufficient to finance our operations and capital expenditures for at least 12 months from the date of this filing.

## REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our Medicaid Managed Care operations are conducted through our subsidiaries. As managed care organizations, these subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of June 30, 2005, our subsidiaries had aggregate statutory capital and surplus of $149.2 million, compared with the required minimum aggregate statutory capital and surplus requirements of $72.1 million.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of June 30, 2005, our Indiana, Ohio, Texas and Wisconsin health plans were in compliance with risk-based capital requirements. If adopted by Kansas, Missouri or New Jersey, risk-based capital may increase the minimum capital required for these subsidiaries. We continue to monitor the requirements in Kansas, Missouri and New Jersey and do not expect that they will have a material impact on our results of operations, financial position or cash flows.

## RECENT ACCOUNTING PRONOUNCEMENTS

In December 2004 SFAS 123 (revised 2004), "Share Based Payment," (SFAS 123R) was issued. In March 2005 the SEC issued Staff Accounting Bulletin No. 107 (SAB 107). SAB 107 expresses views of the SEC staff regarding the interaction between SFAS 123R and certain SEC rules. SFAS 123R focuses primarily on accounting for transactions in which an entity obtains employee services in share-based payment transactions. SFAS 123R requires public entities to measure the cost of employee services received in exchange for an award of equity instruments based on the grant-date fair value of the award. The grant-date fair value of employee share options and similar instruments will be estimated using option-pricing models adjusted for the unique characteristics of those instruments. That cost will be recognized over the period during which an employee is required to provide service in exchange for the award. In April 2005 the SEC delayed the implementation of SFAS 123R for public companies until the first annual period beginning after June 15, 2005. We are required to adopt SFAS 123R by January 1, 2006.

We currently utilize a closed form option-pricing model to measure the fair value of stock-based compensation for employees. SFAS 123R permits the use of this model or other models such as a lattice model. We have not yet determined which model we will use to measure the fair value of share-based grants to employees upon the adoption of SFAS 123R. The effect of expensing stock options in accordance with the original SFAS 123 is presented in Note 2 of our Notes to Consolidated Financial Statements included elsewhere in this Form 10-Q. SFAS 123R also requires that the benefits associated with the tax deductions in excess of recognized compensation cost be reported as a financing cash flow, rather than as an operating cash flow as required under current literature. This presentation may reduce net operating cash flows and increase net financing cash flows in periods after the effective date. The amount of this excess tax deduction benefit was $3.8 million and $1.5 million in the six months ended June 30, 2005 and 2004, respectively.

In May 2005, SFAS No. 154, "Accounting Changes and Error Corrections – replacement of APB Opinion No. 20 and FASB Statement No. 3," (SFAS No. 154) was issued. SFAS No. 154 changes the accounting for and reporting of a change in accounting principle by requiring retrospective application to prior periods' financial statements of changes in accounting principle unless impracticable. SFAS No. 154 is effective for accounting changes made in fiscal years beginning after December 15, 2005. We do not expect the adoption of SFAS No. 154 to have a material impact on our results of operations, financial position or cash flows.

## FORWARD-LOOKING STATEMENTS

This filing contains forward-looking statements that relate to future events or our future financial performance. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "goal," "may," "will," "should," "can," "continue" or the negative of these terms or other comparable terminology. These statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the section of this filing entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations." Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

Actual results may differ from projections or estimates due to a variety of important factors. Our results of operations and projections of future earnings depend in large part on accurately predicting and effectively managing health benefits and other

operating expenses. A variety of factors, including competition, changes in healthcare practices, changes in federal or state laws and regulations or their interpretations, inflation, provider contract changes, new technologies, government-imposed surcharges, taxes or assessments, reduction in provider payments by governmental payers, major epidemics, disasters and numerous other factors affecting the delivery and cost of healthcare, such as major healthcare providers' inability to maintain their operations, may in the future affect our ability to control our medical costs and other operating expenses. Governmental action or business conditions could result in premium revenues not increasing to offset any increase in medical costs and other operating expenses. Once set, premiums are generally fixed for one-year periods and, accordingly, unanticipated costs during such periods cannot be recovered through higher premiums. The expiration, cancellation or suspension of our Medicaid managed care contracts by the state governments would also negatively affect us. Due to these factors and risks, we cannot give assurances with respect to our future premium levels or our ability to control our future medical costs.

## FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

### Risks Related to Being a Regulated Entity

***Reduction in Medicaid, SCHIP and SSI Funding Could Substantially Reduce Our Profitability.***

Most of our revenues come from Medicaid, SCHIP and SSI premiums. The base premium rate paid by each state differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix and member eligibility categories. Future levels of Medicaid, SCHIP and SSI funding and premium rates may be affected by continued government efforts to contain medical costs and may further be affected by state and federal budgetary constraints. For example, in August 2004, the Centers for Medicare & Medicaid Services, or CMS, proposed a rule requiring states to estimate improper payments made under their Medicaid and SCHIP programs, report such overpayments to Congress, and, if necessary, take actions to reduce erroneous payments. In February 2005, the Bush administration called for changes in Medicaid that would cut payments for prescription drugs and give states new power to reduce or reconfigure benefits. Changes to Medicaid, SCHIP and SSI programs could reduce the number of persons enrolled or eligible, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under those programs. States periodically consider reducing or reallocating the amount of money they spend for Medicaid, SCHIP and SSI. Over the past two years, the majority of states have implemented measures to restrict Medicaid, SCHIP and SSI costs and eligibility. We believe that reductions in Medicaid, SCHIP and SSI payments could substantially reduce our profitability. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds.

***If Our Medicaid and SCHIP Contracts are Terminated or are Not Renewed, Our Business Will Suffer.***

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicaid, SSI and SCHIP. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. The contracts expire on various dates between August 31, 2005 and August 31, 2007. Our contracts may be terminated if we fail to perform up to the standards set by state regulatory agencies. In addition, the Indiana contract under which we operate can be terminated by the state without cause. Our contracts are generally intended to run for one or two years and may be extended for one or two additional years if the state or its contractor elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. If any of our contracts are terminated, not renewed, or renewed on less favorable terms, our business will suffer, and our operating results may be materially affected.

***Changes in Government Regulations Designed to Protect the Financial Interests of Providers and Members Rather Than Our Stockholders Could Force Us to Change How We Operate and Could Harm Our Business.***

Our business is extensively regulated by the states in which we operate and by the federal government. The applicable laws and regulations are subject to frequent change and generally are intended to benefit and protect the financial interests of health plan providers and members rather than stockholders. Changes in existing laws and rules, the enactment of new laws and rules or changing interpretations of these laws and rules could, among other things:

- force us to restructure our relationships with providers within our network;
- require us to implement additional or different programs and systems;

- mandate minimum medical expense levels as a percentage of premiums revenues;
- restrict revenue and enrollment growth;
- require us to develop plans to guard against the financial insolvency of our providers;
- increase our healthcare and administrative costs;
- impose additional capital and reserve requirements; and
- increase or change our liability to members in the event of malpractice by our providers.

For example, Congress has considered various forms of patient protection legislation commonly known as the Patients' Bill of Rights and the legislation is frequently proposed in Congress. We cannot predict the impact of this legislation, if adopted, on our business.

***Regulations May Decrease the Profitability of Our Health Plans.***

Our Texas plan is required to pay a rebate to the state in the event profits exceed established levels. Similarly, our New Jersey plan is required to pay a rebate to the state in the event its health benefits ratio is less than 80%. These regulatory requirements, changes in these requirements or the adoption of similar requirements by our other regulators may limit our ability to increase our overall profits as a percentage of revenues. The states of Indiana, New Jersey and Texas have implemented prompt-payment laws and are enforcing penalty provisions for failure to pay claims in a timely manner. Failure to meet these requirements can result in financial fines and penalties. In addition, states may attempt to reduce their contract premium rates if regulators perceive our health benefits ratio as too low. Any of these regulatory actions could harm our operating results.

In recent years, CMS has reduced the rates at which states are permitted to reimburse non-state government-owned or operated hospitals for inpatient and outpatient hospital services. The upper limit is currently 100% of Medicare payments for comparable services. Any further reductions in this limit could decrease the profitability of our health plans.

***Failure to Comply With Government Regulations Could Subject Us to Civil and Criminal Penalties.***

Federal and state governments have enacted fraud and abuse laws and other laws to protect patients' privacy and access to healthcare. Violation of these and other laws or regulations governing our operations or the operations of our providers could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide services, the suspension or revocation of our licenses or our exclusion from participating in the Medicaid, SSI and SCHIP programs. If we were to become subject to these penalties or exclusions as the result of our actions or omissions or our inability to monitor the compliance of our providers, it would negatively affect our ability to operate our business. For example, failure to pay our providers promptly could result in the imposition of fines and other penalties. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations.

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse. Further, HIPAA imposes civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of most individually identifiable health information. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules.

***We Will Incur Significant Increased Costs As a Result of Compliance With New Government Regulations And Our Management Will Be Required to Devote Substantial Time To Compliance.***

The issuance of future judicial or regulatory guidance regarding the interpretation of regulations, the states' ability to promulgate stricter rules, and continuing uncertainty regarding many aspects of the regulations' implementation may make compliance with this

regulatory landscape difficult. For example, our existing programs and systems may not enable us to comply in all respects with new security regulations. In order to comply with new regulatory requirements, we were required to employ additional or different programs and systems. Further, compliance with new regulations could require additional changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover from the states our costs of complying with these new regulations. The new regulations and the related compliance costs could have a material adverse effect on our business.

In addition, the Sarbanes-Oxley Act, as well as rules subsequently implemented by the SEC and the New York Stock Exchange, have imposed various requirements on public companies, including requiring changes in corporate governance practices. Our management and other personnel will need to devote a substantial amount of time to these new compliance initiatives. Moreover, these rules and regulations will increase our legal and financial compliance costs and will make some activities more time-consuming and costly.

The Sarbanes-Oxley Act requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on the effectiveness of our internal controls over our financial reporting as required by Section 404 of the Sarbanes-Oxley Act. Our testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 requires that we incur substantial accounting expense and expend significant management efforts. Moreover, if we are not able to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

***Changes in Healthcare Law and Benefits May Reduce Our Profitability.***

Numerous proposals relating to changes in healthcare law have been introduced, some of which have been passed by Congress and the states in which we operate or may operate in the future. Changes in applicable laws and regulations are continually being considered, and interpretations of existing laws and rules may also change from time to time. We are unable to predict what regulatory changes may occur or what effect any particular change may have on our business. For example, these changes could reduce the number of persons enrolled or eligible for Medicaid, reduce the reimbursement or payment levels for medical services or reduce benefits included in Medicaid coverage. More generally, we are unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare. Legislation or regulations that require us to change our current manner of operation, provide additional benefits or change our contract arrangements may seriously harm our operations and financial results.

***If a State Fails to Renew its Federal Waiver Application for Mandated Medicaid Enrollment into Managed Care or Such Application is Denied, Our Membership in That State Will Likely Decrease.***

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two-year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, membership in our health plans could decrease and our business could suffer.

***Changes in Federal Funding Mechanisms May Reduce Our Profitability.***

The Bush Administration has proposed a major long-term change in the way Medicaid and SCHIP are funded. The proposal, if adopted, would allow states to elect to receive, instead of federal matching funds, combined Medicaid-SCHIP "allotments" for acute and long-term healthcare for low-income, uninsured persons. Participating states would be given flexibility in designing their own health insurance programs, subject to federally-mandated minimum coverage requirements. It is uncertain whether this proposal will be enacted, or if so, how it may change from a similar proposal initiated by the Bush Administration in February 2003. Accordingly, it is unknown whether or how many states might elect to participate or how their participation may affect the net amount of funding available for Medicaid and SCHIP programs. If such a proposal is adopted and decreases the number of persons enrolled in Medicaid or SCHIP in the states in which we operate or reduces the volume of healthcare services provided, our growth, operations and financial performance could be adversely affected.

In April 2004, the Bush Administration adopted a new policy that seeks to reduce states' use of intergovernmental transfers for the states' share of Medicaid program funding. By restricting the use of intergovernmental transfers as part of states' Medicaid contributions, this policy, if continued, may restrict some states' funding for Medicaid, which could adversely affect our growth, operations and financial performance.

In February 2005, the Bush Administration called for changes in Medicaid that would cut payments for prescription drugs and give states new power to reduce or reconfigure benefits. Any reduction or reconfiguration of state funding could adversely affect our growth, operations and financial performance.

Recent legislative changes in the Medicare program may also affect our business. For example, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, enacted in December 2003, will, upon taking effect in 2006, revise cost-sharing requirements for some beneficiaries and require states to reimburse the federal Medicare program for costs of prescription drug coverage provided to beneficiaries who are enrolled simultaneously in both the Medicaid and Medicare programs. These changes may reduce the availability of funding for some states' Medicaid programs, which could adversely affect our growth, operations and financial performance.

***If State Regulatory Agencies Require a Statutory Capital Level Higher than the State Regulations, We May Be Required to Make Additional Capital Contributions.***

Our operations are conducted through our wholly owned subsidiaries, which include HMOs and managed care organizations, or MCOs. HMOs and MCOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Additionally, state regulatory agencies may require, at their discretion, individual HMO's to maintain statutory capital levels higher than the state regulations. If this were to occur to one of our subsidiaries, we may be required to make additional capital contributions to the affected subsidiary. Any additional capital contribution made to one of the affected subsidiaries could have a material adverse effect on our liquidity and our ability to grow.

***If We Are Unable to Participate in SCHIP Programs, Our Growth Rate May be Limited.***

SCHIP is a federal initiative designed to provide coverage for low-income children not otherwise covered by Medicaid or other insurance programs. The programs vary significantly from state to state. Participation in SCHIP programs is an important part of our growth strategy. If states do not allow us to participate or if we fail to win bids to participate, our growth strategy may be materially and adversely affected.

***If State Regulators Do Not Approve Payments of Dividends and Distributions by Our Subsidiaries to Us, We May Not Have Sufficient Funds to Implement Our Business Strategy.***

We principally operate through our health plan subsidiaries. If funds normally available to us become limited in the future, we may need to rely on dividends and distributions from our subsidiaries to fund our operations. These subsidiaries are subject to regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny our subsidiaries' request to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy.

**Risks Related to Our Business**

***Receipt of Inadequate Premiums Would Negatively Affect Our Revenues and Profitability.***

Nearly all of our revenues are generated by premiums consisting of fixed monthly payments per member. These premiums are fixed by contract, and we are obligated during the contract periods to provide healthcare services as established by the state governments. We use a large portion of our revenues to pay the costs of healthcare services delivered to our members. If premiums do not increase when expenses related to medical services rise, our earnings will be affected negatively. In addition, our actual medical services costs may exceed our estimates, which would cause our health benefits ratio, or our expenses related to medical services as a percentage of premium revenues, to increase and our profits to decline. In addition, it is possible for a state to increase the rates payable to the hospitals without granting a corresponding increase in premiums to us. If this were to occur in one or more of the states in which we operate, our profitability would be harmed.

***Failure to Effectively Manage Our Medical Costs or Related Administrative Costs Would Reduce Our Profitability.***

Our profitability depends, to a significant degree, on our ability to predict and effectively manage expenses related to health benefits. We have less control over the costs related to medical services than we do over our general and administrative expenses. Historically, our health benefits ratio has fluctuated. For example, over the last six years, our health benefits ratio has ranged from 80.7% to 88.9%. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of use of healthcare services, hospital costs, pharmaceutical costs, major epidemics, new medical technologies and other external factors, including general economic conditions such as inflation levels, are beyond our control and could reduce our ability to predict and effectively control the costs of providing health benefits. We may not be able to manage costs effectively in the future. If our costs related to health benefits increase, our profits could be reduced or we may not remain profitable.

***Failure to Accurately Predict Our Medical Expenses Could Negatively Affect Our Reported Results.***

Our medical expenses include estimates of IBNR medical expenses. We estimate our IBNR medical expenses monthly based on a number of factors. Adjustments, if necessary, are made to medical expenses in the period during which the actual claim costs are ultimately determined or when criteria used to estimate IBNR change. We cannot be sure that our IBNR estimates are adequate or that adjustments to those estimates will not harm our results of operations. From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. Our failure to estimate IBNR accurately may also affect our ability to take timely corrective actions, further harming our results.

***Difficulties in Executing Our Acquisition Strategy Could Adversely Affect Our Business.***

Historically, the acquisition of Medicaid businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets has accounted for a significant amount of our growth. Many of the other potential purchasers of Medicaid assets have greater financial resources than we have. In addition, many of the sellers are interested either in (a) selling, along with their Medicaid assets, other assets in which we do not have an interest or (b) selling their companies, including their liabilities, as opposed to the assets of their ongoing businesses.

We generally are required to obtain regulatory approval from one or more state agencies when making acquisitions. In the case of an acquisition of a business located in a state in which we do not currently operate, we would be required to obtain the necessary licenses to operate in that state. In addition, even if we already operate in a state in which we acquire a new business, we would be required to obtain additional regulatory approval if the acquisition would result in our operating in an area of the state in which we did not operate previously, and we could be required to renegotiate provider contracts of the acquired business. We cannot assure you that we would be able to comply with these regulatory requirements for an acquisition in a timely manner, or at all. In deciding whether to approve a proposed acquisition, state regulators may consider a number of factors outside our control, including giving preference to competing offers made by locally owned entities or by not-for-profit entities. Furthermore, our credit facility may prohibit some acquisitions without the consent of our bank lender.

In addition to the difficulties we may face in identifying and consummating acquisitions, we will also be required to integrate and consolidate any acquired business or assets with our existing operations. This may include the integration of:

- additional personnel who are not familiar with our operations and corporate culture;
- provider networks that may operate on different terms than our existing networks;
- existing members, who may decide to switch to another healthcare plan; and
- disparate administrative, accounting and finance, and information systems.

Accordingly, we may be unable to identify, consummate and integrate future acquisitions successfully or operate acquired businesses profitably. We also may be unable to obtain sufficient additional capital resources for future acquisitions. If we are unable to effectively execute our acquisition strategy, our future growth will suffer and our results of operations could be harmed.

***If Competing Managed Care Programs are Unwilling to Purchase Specialty Services From Us, We May Not be Able to Successfully Implement Our Strategy of Diversifying Our Business Lines.***

We are seeking to diversify our business lines into areas that complement our Medicaid business in order to grow our revenue stream and balance our dependence on Medicaid risk reimbursement. In 2003, for example, we acquired Cenpatico Behavioral Health,

a behavioral health services company, and purchased contract and name rights of ScriptAssist, a treatment compliance company. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our Medicaid programs. Our inability to market specialty services to other programs may impair our ability to execute our business strategy.

***Failure to Achieve Timely Profitability in Any Business Would Negatively Affect Our Results of Operations.***

Start-up costs associated with a new business can be substantial. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to obtain a state contract and process claims. If we were unsuccessful in obtaining the necessary license, winning the bid to provide service or attracting members in numbers sufficient to cover our costs, any new business of ours would fail. We also could be obligated by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or recover start-up costs. The expenses associated with starting up a new business could have a significant impact on our results of operations if we are unable to achieve profitable operations in a timely fashion.

***We Derive a Majority of Our Premium Revenues From Operations in a Small Number of States, and Our Operating Results Would be Materially Affected by a Decrease in Premium Revenues or Profitability in Any One of Those States.***

Operations in Indiana, Kansas, Missouri, New Jersey, Ohio, Texas and Wisconsin have accounted for most of our premium revenues to date. If we were unable to continue to operate in each of those states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative actions, economic conditions and similar factors in those states. Our inability to continue to operate in any of the states in which we operate would harm our business.

***Competition May Limit Our Ability to Increase Penetration of the Markets That We Serve.***

We compete for members principally on the basis of size and quality of provider network, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided. Subject to limited exceptions by federally approved state applications, the federal government requires that there be choices for Medicaid recipients among managed care programs. Voluntary programs and mandated competition may limit our ability to increase our market share.

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as in industries that act as suppliers to us, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

In addition, in order to increase our membership in the markets we currently serve, we believe that we must continue to develop and implement community-specific products, alliances with key providers and localized outreach and educational programs. If we are unable to develop and implement these initiatives, or if our competitors are more successful than we are in doing so, we may not be able to further penetrate our existing markets.

***If We are Unable to Maintain Satisfactory Relationships With Our Provider Networks, Our Profitability Will be Harmed.***

Our profitability depends, in large part, upon our ability to contract favorably with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be cancelled by either party without cause upon 90 to 120 days prior written notice. We cannot assure you that we will be able to continue to renew our existing contracts or enter into new contracts enabling us to service our members profitably.

From time to time providers assert or threaten to assert claims seeking to terminate noncancelable agreements due to alleged actions or inactions by us. Even if these allegations represent attempts to avoid or renegotiate contractual terms that have become economically disadvantageous to the providers, it is possible that in the future a provider may pursue such a claim successfully. In

addition, we are aware that other managed care organizations have been subject to class action suits by physicians with respect to claim payment procedures, and we may be subject to similar claims. Regardless of whether any claims brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

We will be required to establish acceptable provider networks prior to entering new markets. We may be unable to enter into agreements with providers in new markets on a timely basis or under favorable terms.

If we are unable to retain our current provider contracts or enter into new provider contracts timely or on favorable terms, our profitability will be harmed.

***Changes in Stock Option Accounting Rules May Have a Significant Adverse Affect on Our Operating Results.***

We have a history of using broad based employee stock option programs to hire, incentivize and retain our workforce in a competitive marketplace. Statement of Financial Accounting Standards No. 123, "Accounting for Stock-Based Compensation," allows companies the choice of either using a fair value method of accounting for options that would result in expense recognition for all options granted, or using an intrinsic value method, as prescribed by Accounting Principles Board Opinion No. 25, "Accounting for Stock Issued to Employees," or APB 25, with a pro forma disclosure of the impact on net income (loss) of using the fair value option expense recognition method. We have previously elected to apply APB 25, and, accordingly, we generally have not recognized any expense with respect to employee stock options as long as such options are granted at exercise prices equal to the fair value of our common stock on the date of grant.

In December 2004, the Financial Accounting Standards Board issued SFAS 123R which would require all companies to measure compensation cost for all share-based payments, including employee stock options, at fair value. In April 2005 the SEC delayed the implementation until the first annual period beginning after June 15, 2005. We are required to adopt SFAS 123R by January 1, 2006. The effect of expensing stock options in accordance with the original SFAS 123 is presented in Note 2 of our Notes to Consolidated Financial Statements included elsewhere in this Form 10-Q. SFAS 123R also requires that the benefits associated with the tax deductions in excess of recognized compensation cost be reported as a financing cash flow, rather than as an operating cash flow as required under current literature. This presentation may reduce net operating cash flows and increase net financing cash flows in periods after the effective date. The amount of this excess tax deduction benefit was $3.8 million and $1.5 million in the six months ended June 30, 2005 and 2004, respectively.

***We May be Unable to Attract and Retain Key Personnel.***

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. If we lose one or more members of our senior management team, including our chief executive officer, Michael F. Neidorff, who has been instrumental in developing our business strategy and forging our business relationships, our business and operating results could be harmed. Our ability to replace any departed members of our senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the Medicaid managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel.

***Negative Publicity Regarding the Managed Care Industry May Harm Our Business and Operating Results.***

The managed care industry has received negative publicity. This publicity has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. These factors may adversely affect our ability to market our services, require us to change our services, and increase the regulatory burdens under which we operate. Any of these factors may increase the costs of doing business and adversely affect our operating results.

***Claims Relating to Medical Malpractice Could Cause Us to Incur Significant Expenses.***

Our providers and employees involved in medical care decisions may be subject to medical malpractice claims. In addition, some states, including Texas, have adopted legislation that permits managed care organizations to be held liable for negligent treatment decisions or benefits coverage determinations. Claims of this nature, if successful, could result in substantial damage awards against us and our providers that could exceed the limits of any applicable insurance coverage. Therefore, successful malpractice or tort claims asserted against us, our providers or our employees could adversely affect our financial condition and profitability. Even if any claims brought against us are unsuccessful or without merit, they would still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

***Loss of Providers Due to Increased Insurance Costs Could Adversely Affect Our Business.***

Our providers routinely purchase insurance to help protect themselves against medical malpractice claims. In recent years, the costs of maintaining commercially reasonable levels of such insurance have increased dramatically, and these costs are expected to increase to even greater levels in the future. As a result of the level of these costs, providers may decide to leave the practice of medicine or to limit their practice to certain areas, which may not address the needs of Medicaid participants. We rely on retaining a sufficient number of providers in order to maintain a certain level of service. If a significant number of our providers exit our provider networks or the practice of medicine generally, we may be unable to replace them in a timely manner, if at all, and our business could be adversely affected.

***Growth in the Number of Medicaid-Eligible Persons During Economic Downturns Could Cause Our Operating Results and Stock Prices to Suffer if State and Federal Budgets Decrease or Do Not Increase.***

Less favorable economic conditions may cause our membership to increase as more people become eligible to receive Medicaid benefits. During such economic downturns, however, state and federal budgets could decrease, causing states to attempt to cut healthcare programs, benefits and rates. We cannot predict the impact of changes in the United States economic environment or other economic or political events, including acts of terrorism or related military action, on federal or state funding of healthcare programs or on the size of the population eligible for the programs we operate. If federal funding decreases or remains unchanged while our membership increases, our results of operations will suffer.

***Growth in the Number of Medicaid-Eligible Persons May be Countercyclical, Which Could Cause Our Operating Results to Suffer When General Economic Conditions are Improving.***

Historically, the number of persons eligible to receive Medicaid benefits has increased more rapidly during periods of rising unemployment, corresponding to less favorable general economic conditions. Conversely, this number may grow more slowly or even decline if economic conditions improve. Therefore, improvements in general economic conditions may cause our membership levels to decrease, thereby causing our operating results to suffer, which could lead to decreases in our stock price during periods in which stock prices in general are increasing.

***We Intend to Expand Our Medicaid Managed Care Business Primarily into Markets Where Medicaid Recipients are Required to Enroll in Managed Care Plans.***

We expect to continue to focus our business in states in which Medicaid enrollment in managed care is mandatory. Currently, approximately two-thirds of the states require health plan enrollment for Medicaid eligible participants in all or a portion of their counties. The programs are voluntary in other states. Because we concentrate on markets with mandatory enrollment, we expect the geographic expansion of our Medicaid Managed Care segment to be limited to those states.

***If We are Unable to Integrate and Manage Our Information Systems Effectively, Our Operations Could be Disrupted.***

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status and other information.

Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs. Moreover, our acquisition activity requires frequent transitions to or from, and the integration of, various information systems. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, from operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

***We Rely on the Accuracy of Eligibility Lists Provided by State Governments. Inaccuracies in Those Lists Would Negatively Affect Our Results of Operations.***

Premium payments to us are based upon eligibility lists produced by state governments. From time-to-time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we had made related payments to providers and were unable to recoup such payments from the providers.

***We May Not be Able to Obtain or Maintain Adequate Insurance.***

We maintain liability insurance, subject to limits and deductibles, for claims that could result from providing or failing to provide managed care and related services. These claims could be substantial. We believe that our present insurance coverage and reserves are adequate to cover currently estimated exposures. We cannot assure you that we will be able to obtain adequate insurance coverage in the future at acceptable costs or that we will not incur significant liabilities in excess of policy limits.

**ITEM 3.** ***Quantitative and Qualitative Disclosures About Market Risk.***

**INVESTMENTS**

As of June 30, 2005, we had short-term investments of $65.3 million and long-term investments of $156.9 million, including restricted deposits of $22.3 million. The short-term investments consist of highly liquid securities with maturities between three and twelve months. The long-term investments consist of municipal, corporate and U.S. agency bonds, life insurance contracts and U.S. Treasury investments and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2005, the fair value of our fixed income investments would decrease by approximately $3.9 million. Declines in interest rates over time will reduce our investment income.

**INFLATION**

Although the general rate of inflation has remained relatively stable and healthcare cost inflation has stabilized in recent years, the national healthcare cost inflation rate still exceeds the general inflation rate. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations or other factors may affect our ability to control the impact of healthcare cost increases.

**COMPLIANCE COSTS**

Federal and state regulations governing standards for electronic transactions, data security and confidentiality of patient information have been issued recently. Due to the uncertainty surrounding the regulatory requirements, we cannot be sure that the systems and programs that we have implemented will comply adequately with the security regulations that are ultimately adopted. Implementation of additional systems and programs may be required. Further, compliance with these regulations would require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover our costs of complying with these new regulations from the states.

**ITEM 4.** ***Controls and Procedures.***

**Evaluation of Disclosure Controls and Procedures**

As of June 30, 2005, an evaluation was carried out under the supervision and with the participation of the Company's management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures (as defined in Rules 13a–15(e) and 15d–15(e) under the Securities Exchange Act of 1934). Based upon that evaluation, the Chief Executive Officer and the Chief Financial Officer concluded that the design and operation of these disclosure controls and procedures were effective to ensure that information required to be disclosed by the company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in applicable rules and forms.

**Changes in Internal Control Over Financial Reporting During the Quarter Ended June 30, 2005**

There were no significant changes in our internal control over financial reporting that occurred during the Company's quarter ended June 30, 2005 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

## PART II

## OTHER INFORMATION

**ITEM 1.** ***Legal Proceedings.***

Aurora Health Care, Inc. (Aurora) provides medical professional services under a contract with our Wisconsin health plan subsidiary. In May 2003, Aurora filed a lawsuit in the Milwaukee County Circuit Court claiming we had failed to adequately reimburse Aurora for services rendered during the period from 1998 to the present. In 2004 the Court dismissed the claims as filed, but allowed Aurora to replead and seek a declaratory ruling clarifying the contract with respect to reimbursement for ambulatory surgery services. In March 2005, the Court granted Aurora summary judgment related to that claim. We are appealing the Court's ruling. Although the exact amount of the dispute has not been determined, Aurora claims it exceeds $8 million. We continue to dispute the claim and plan to continue vigorously defending this matter.

We are routinely subject to legal proceedings in the normal course of business. While the ultimate resolution of such matters are uncertain, we do not expect the result of these matters to have a material effect on our financial position or results of operations.

**ITEM 2.** ***Unregistered Sales of Equity Securities and Use of Proceeds.***

None.

**ITEM 3.** ***Defaults Upon Senior Securities.***

None.

**ITEM 4.** ***Submission of Matters to a Vote of Security Holders.***

We held our annual meeting of stockholders on April 26, 2005. At the meeting, Michael F. Neidorff and John R. Roberts were reelected as Class I Directors. The votes with respect to each nominee are set forth below:

| | Total Vote for Each Director | Total Vote Withheld From Each Director |
|---|---|---|
| Mr. Neidorff | 37,475,532 | 1,263,659 |
| Mr. Roberts | 36,182,007 | 2,557,184 |

Additional directors of the Company whose terms of office continued after the meeting are Steve Bartlett, Robert K. Ditmore, David L. Steward and Tommy G. Thompson.

**ITEM 5.** ***Other Information.***

None.

Table of Contents

**ITEM 6.** ***Exhibits***

Exhibits.

| EXHIBIT NUMBER | DESCRIPTION |
|---|---|
| 10.1 | Form of Executive Severance and Change in Control Agreement, incorporated herein by reference to Exhibit 10.1 of Form 8-K filed May 23, 2005. |
| 10.2 | Amendment Seventeen to the Kansas Healthwave Title XIX and Title XXI Capitated Managed Care Health Services Contract with FirstGuard Health Plan Kansas, Inc. 2006 Renewal, incorporated herein by reference to Exhibit 10.1 of Form 8-K filed July 8, 2005. |
| 10.3 | First Amendment to Contract Between the Office of Medicaid Policy and Planning, The Office of the Children's Health Insurance Program and Coordinated Care Corporation Indiana, Inc., incorporated herein by reference to Exhibit 10.2 of Form 8-K filed July 8, 2005. |
| 12.1 | Computation of ratio of earnings to fixed charges. |
| 31.1 | Certification of Chairman and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended. |
| 31.2 | Certification of Senior Vice President, Chief Financial Officer, Secretary and Treasurer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended. |
| 32.1 | Certification of Chairman and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. |
| 32.2 | Certification of Senior Vice President, Chief Financial Officer, Secretary and Treasurer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. |

**SIGNATURES**

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized as of July 25, 2005.

CENTENE CORPORATION

By: /S/ MICHAEL F. NEIDORFF

Michael F. Neidorff
Chairman and Chief Executive Officer
*(principal executive officer)*

By: /S/ KAREY L. WITTY

Karey L. Witty
Senior Vice President, Chief Financial Officer,
Secretary and Treasurer
*(principal financial and accounting officer)*

**Exhibit 12.1**

Centene Corporation
Computation of ratio of earnings to fixed charges
($ in thousands)

| | For the Six Months Ended, | Year ended December 31, | | | | |
|---|---|---|---|---|---|---|
| | June 30, 2005 | 2004 | 2003 | 2002 | 2001 | 2000 |
| Earnings: | | | | | | |
| Pre-tax earnings from continuing operations | $ 47,085 | $ 70,287 | $ 51,893 | $ 41,136 | $ 22,026 | $ 7,185 |
| Addback: | | | | | | |
| Fixed charges | 2,347 | 2,489 | 1,232 | 915 | 1,058 | 1,067 |
| Total earnings | $ 49,432 | $ 72,776 | $ 53,125 | $ 42,051 | $ 23,084 | $ 8,252 |
| Fixed Charges: | | | | | | |
| Interest expense | $ 1,196 | $ 680 | $ 194 | $ 45 | $ 362 | $ 611 |
| Interest component of rental payments (1) | 1,151 | 1,809 | 1,038 | 870 | 696 | 456 |
| Total fixed charges | $ 2,347 | $ 2,489 | $ 1,232 | $ 915 | $ 1,058 | $ 1,067 |
| Ratio of earnings to fixed charges | 21.06 | 29.24 | 43.12 | 45.96 | 21.82 | 7.73 |

(1) Estimated at 33% of rental expense as a reasonable approximation of the interest factor.

**EXHIBIT 31.1**

**CERTIFICATION**

I, Michael F. Neidorff, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules13a-15(e) and 15d-15(e)) and internal controls over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
    a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this quarterly report is being prepared;
    b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
    c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
    d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent function):
    a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
    b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 25, 2005

/S/ MICHAEL F. NEIDORFF

Michael F. Neidorff
Chairman and Chief Executive Officer
*(principal executive officer)*

**EXHIBIT 31.2**

**CERTIFICATION**

I, Karey L. Witty, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules13a-15(e) and 15d-15(e)) and internal controls over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
    a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this quarterly report is being prepared;
    b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
    c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
    d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent function):
    a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
    b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 25, 2005

/S/ KAREY L. WITTY

Karey L. Witty
Senior Vice President, Chief Financial Officer,
Secretary and Treasurer
*(principal financial and accounting officer)*

**EXHIBIT 32.1**

**CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,**
**AS ADOPTED PURSUANT TO**
**SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the quarterly report on Form 10-Q of Centene Corporation (the "Company") for the period ended June 30, 2005, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned, Michael F. Neidorff, Chairman, President and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities and Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/S/ MICHAEL F. NEIDORFF
Michael F. Neidorff
Chairman and Chief Executive Officer
*(principal executive officer)*

Dated: July 25, 2005

**EXHIBIT 32.2**

**CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,**
**AS ADOPTED PURSUANT TO**
**SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the quarterly report on Form 10-Q of Centene Corporation (the "Company") for the period ended June 30, 2005, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned, Karey L. Witty, Senior Vice President, Chief Financial Officer, Secretary and Treasurer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities and Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/S/ KAREY L. WITTY
Karey L. Witty
Senior Vice President, Chief Financial Officer, Secretary and Treasurer
*(principal financial and accounting officer)*

Dated: July 25, 2005